		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045377

Facility Name: Prairie City Health Care Center

Address: 825 E Main St. (Number) Prairie City (City) 61470 (Zip Code)

County: McDonough

Telephone Number: (309) 775 - 3313 **Fax #** (309) 775 - 3311

IDPA ID Number: 371409457001

Date of Initial License for Current Owners: 04/30/01

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Christine Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 04/30/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	11,808	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	48	TOTALS	48	11,808	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	4,147	3,153		7,300	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,147	3,153		7,300	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.82%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/30/01

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 04/30/01 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center # 0045377 **Report Period Beginning:** 04/30/01 **Ending:** 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	54,343	5,042	1,233	60,618		60,618	7	60,625			1
2	Food Purchase		34,461		34,461		34,461		34,461			2
3	Housekeeping	36,504	5,211		41,715		41,715		41,715			3
4	Laundry	8,867	4,290		13,157		13,157		13,157			4
5	Heat and Other Utilities			15,417	15,417		15,417	120	15,537			5
6	Maintenance	7,534	17,502	2,899	27,935		27,935	147	28,082			6
7	Other (specify):*											7
8	**TOTAL General Services**	107,248	66,506	19,549	193,303		193,303	274	193,577			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	219,486	20,408	1,298	241,192		241,192		241,192			10
10a	Therapy			826	826		826		826			10a
11	Activities	21,123	246	664	22,033		22,033		22,033			11
12	Social Services	11,422		664	12,086		12,086	1	12,087			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	252,031	20,654	3,452	276,137		276,137	1	276,138			16
	C. General Administration											
17	Administrative	59,109		(2,697)	56,412		56,412	2,697	59,109			17
18	Directors Fees											18
19	Professional Services			9,744	9,744		9,744	1,007	10,751			19
20	Dues, Fees, Subscriptions & Promotions			5,670	5,670		5,670	93	5,763			20
21	Clerical & General Office Expenses	7,008	2,769	11,136	20,913		20,913	2,845	23,758			21
22	Employee Benefits & Payroll Taxes			50,877	50,877		50,877	3,726	54,603			22
23	Inservice Training & Education			49	49		49	13	62			23
24	Travel and Seminar			2,627	2,627		2,627	390	3,017			24
25	Other Admin. Staff Transportation			728	728		728	435	1,163			25
26	Insurance-Prop.Liab.Malpractice			2,128	2,128		2,128	540	2,668			26
27	Other (specify):*											27
28	**TOTAL General Administration**	66,117	2,769	80,262	149,148		149,148	11,746	160,894			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	425,396	89,929	103,263	618,588		618,588	12,021	630,609			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Prairie City Health Care Center #0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			16,867	16,867		16,867	(1,047)	15,820			30
31	Amortization of Pre-Op. & Org.			796	796		796		796			31
32	Interest			7,077	7,077		7,077	287	7,364			32
33	Real Estate Taxes			3,673	3,673		3,673		3,673			33
34	Rent-Facility & Grounds							755	755			34
35	Rent-Equipment & Vehicles			2,078	2,078		2,078	526	2,604			35
36	Other (specify):*											36
37	**TOTAL Ownership**			30,491	30,491		30,491	521	31,012			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			17,568	17,568		17,568		17,568			42
43	Other (specify):* **Nonallowable costs**			13,879	13,879		13,879	(13,879)				43
44	**TOTAL Special Cost Centers**			31,447	31,447		31,447	(13,879)	17,568			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	425,396	89,929	165,201	680,526		680,526	(1,337)	679,189			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(505)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,828)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(131)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(10,105)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,706)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Schedule 5A	(1,484)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (16,759)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	15,422		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 15,422		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,337)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Prairie City Health Care Center
Provider # 0045377
12/31/2001

Schedule 5A

VI. ADJUSTMENT DETAIL
NON-ALLOWABLE EXPENSES
LINE 29 -Other

Description	Amount	Schedule V Reference
Miscellaneous Income	(52)	21
Special Events	(1,403)	43
Vending Machine	(29)	43
Total	**(1,484)**	

SEE ACCOUNTANTS' COMPILATION REPORT

Prairie City Health Care Center

ID# 0045377

Report Period Beginning: 04/30/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Prairie City Health Care Center # 0045377 **Report Period Beginning:** 04/30/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	7	0	0	0	0	0	0	0	0	0	7	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	120	0	0	0	0	0	0	0	0	0	120	5
6	Maintenance	0	147	0	0	0	0	0	0	0	0	0	147	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	274	0	0	0	0	0	0	0	0	0	274	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	1	0	0	0	0	0	0	0	0	0	1	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	1	0	0	0	0	0	0	0	0	0	1	16
	C. General Administration													
17	Administrative	0	2,697	0	0	0	0	0	0	0	0	0	2,697	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,007	0	0	0	0	0	0	0	0	0	1,007	19
20	Fees, Subscriptions & Promotions	0	93	0	0	0	0	0	0	0	0	0	93	20
21	Clerical & General Office Expenses	0	2,897	0	0	0	0	0	0	0	0	0	2,897	21
22	Employee Benefits & Payroll Taxes	0	3,726	0	0	0	0	0	0	0	0	0	3,726	22
23	Inservice Training & Education	0	13	0	0	0	0	0	0	0	0	0	13	23
24	Travel and Seminar	0	390	0	0	0	0	0	0	0	0	0	390	24
25	Other Admin. Staff Transportation	0	435	0	0	0	0	0	0	0	0	0	435	25
26	Insurance-Prop.Liab.Malpractice	0	540	0	0	0	0	0	0	0	0	0	540	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	11,798	0	0	0	0	0	0	0	0	0	11,798	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	12,073	0	0	0	0	0	0	0	0	0	12,073	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie City Health Care Center # 0045377 **Report Period Beginning:** 04/30/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(2,828)	0	1,781	0	0	0	0	0	0	0	0	(1,047)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	287	0	0	0	0	0	0	0	0	287	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	755	0	0	0	0	0	0	0	0	755	34
35	Rent-Equipment & Vehicles	0	0	526	0	0	0	0	0	0	0	0	526	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,828)	0	3,349	0	0	0	0	0	0	0	0	521	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(12,447)	0	0	0	0	0	0	0	0	0	0	(12,447)	43
44	**TOTAL Special Cost Centers**	(12,447)	0	0	0	0	0	0	0	0	0	0	(12,447)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(15,275)	12,073	3,349	0	0	0	0	0	0	0	0	147	45

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Carolyn Petersen	40.00%					
Edward Franciskovich	40.00%	See Attached Schedule		See Attached Schedule		
Mark Petersen	20.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care Companies	0.00%	$ 7	$ 7	1
2	V	5	Utilities		Petersen Health Care Companies	0.00%	120	120	2
3	V	6	Maintenance Supplies		Petersen Health Care Companies	0.00%	147	147	3
4	V	12	Social Services		Petersen Health Care Companies	0.00%	1	1	4
5	V	17	Administrative	(2,697)	Petersen Health Care Companies	0.00%		2,697	5
6	V	19	Professional Services		Petersen Health Care Companies	0.00%	1,007	1,007	6
7	V	20	Fees, Subscriptions & Promotions		Petersen Health Care Companies	0.00%	93	93	7
8	V	21	Clerical & General Office Exp.		Petersen Health Care Companies	0.00%	2,897	2,897	8
9	V	22	Employee Benefits		Petersen Health Care Companies	0.00%	3,726	3,726	9
10	V	23	Inservices Training & Education		Petersen Health Care Companies	0.00%	13	13	10
11	V	24	Travel & Seminar		Petersen Health Care Companies	0.00%	390	390	11
12	V	25	Other Admin. Staff Transport.		Petersen Health Care Companies	0.00%	435	435	12
13	V	26	Insurance-Prop. Liab. Malpractice		Petersen Health Care Companies	0.00%	540	540	13
14	Total			$ (2,697)			$ 9,376	$ * 12,073	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Petersen Health Care Companies	0.00%	$ 1,781	$ 1,781	15
16	V	32	Interest		Petersen Health Care Companies	0.00%	287	287	16
17	V	34	Rent - Facility & Grounds		Petersen Health Care Companies	0.00%	755	755	17
18	V	35	Rent - Equipment & Vehicles		Petersen Health Care Companies	0.00%	526	526	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 3,349	$ * 3,349	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Prairie City Health Care Center
Provider # 0045377
12/31/2001

VII Related Parties-Page 6

Related Nursing Home	City
Robings Manor Nursing Home	Brighton, IL
Countryview Terrace	Louisville, IL
Sunset Manor Nursing Home	Canton, IL
Kewanee Care Home	Kewanee, IL
Arcola Health Care Center	Arcola, IL
Eastview Terrace	Sullivan, IL
Havana Health Care Center	Havana, IL
Prairie City Health Care Center	Prairie City, IL
Out of State Nursing Home	
Friendly Village	Rhinelander, WI
Horizons Unlimited	Rhinelander, WI
Taylor Park	Rhinelander, WI
Passport	Rhinelander, WI
Meadow Lawn Nursing Center	Davenport, IA
Cumberland Heights-Tomahawk	Tomahawk, WI
Maple Park	Rhinelander, WI
Opportunities Unlimited (Workshop setup, no beds)	
Other Related Business Entities	
Petersen Health Care Companies	Peoria, IL Management/ Bookkeeping
Petersen Property	Canton, IL Building-Sunset Manor

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Petersen	President	Administrative	0.00%	547,507	2	3.00%	Salary	$ 18,494	L . 17 C. 1	1
2	Mark Petersen	Secretary	Administrative	20.00%	237,528	2	3.00%	Salary	8,023	L . 17 C. 1	2
3	Todd Petersen	Administration	Administrative	0.00%	69,004	2	3.00%	Salary	2,331	L . 21 C. 1	3
4											4
5											5
6	See Attached Schedule 7A										6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 28,848		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Prairie City Health Care Center
Provider # 0045377
12/31/2001

Schedule 7A

VII. Related Parties (continued)
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.
Compensation Received From Other Nursing Homes

Name	Arcola Health Care	Kewanee Care Center	Bement Health Care	Country View Terrace	Eastview Terrace	Meadow Lawn Nursing	Robings Manor	Sunset Manor	Havana Care Center	Total	Prairie City	Grand Total
James Petersen	88,261	68,695	53,064	14,795	52,568	58,818	60,034	91,851	59,421	547,507	18,494	566,001
Mark Petersen	38,291	29,802	23,021	6,419	22,806	25,517	26,045	39,848	25,779	237,528	8,023	245,551
Todd Petersen	11,124	8,658	6,688	1,865	6,625	7,413	7,566	11,576	7,489	69,004	2,331	71,335
Total Compensation Received From Other Nursing Homes	137,676	107,155	82,773	23,079	81,999	91,748	93,645	143,275	92,689	854,039	28,848	882,887

See Accountants' Compilation Report

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care Companies
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	223416	8	$ 200	$	7,300	$ 7	1
2	5	Utilities	Patient Days	223416	8	3,666		7,300	120	2
3	6	Maintenance Supplies	Patient Days	223416	8	4,490		7,300	147	3
4	12	Social Services	Patient Days	223416	8	40		7,300	1	4
5	19	Professional Services	Patient Days	223416	8	30,834		7,300	1,007	5
6	20	Fees, Subscriptions & Promotions	Patient Days	223416	8	2,859		7,300	93	6
7	21	Clerical & General Office Exp.	Patient Days	223416	8	88,667		7,300	2,897	7
8	22	Employee Benefits	Patient Days	223416	8	114,040		7,300	3,726	8
9	23	Inservice Training & Education	Patient Days	223416	8	402		7,300	13	9
10	24	Travel & Seminar	Patient Days	223416	8	11,946		7,300	390	10
11	25	Other Admin. Staff Transportatio	Patient Days	223416	8	13,319		7,300	435	11
12	26	Insurance	Patient Days	223416	8	16,524		7,300	540	12
13	30	Depreciation	Patient Days	223416	8	54,520		7,300	1,781	13
14	32	Interest	Patient Days	223416	8	8,774		7,300	287	14
15	34	Rent-Facility & Grounds	Patient Days	223416	8	23,100		7,300	755	15
16	35	Rent-Equipment & Vehicles	Patient Days	223416	8	16,083		7,300	526	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 389,464	$		$ 12,725	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bank of Farmington		X	Van	$997.00	12/18/01	$ 59,816	$ 59,816	01/17/07	0.0690	$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Bank		X	Working Capital	Interest	05/15/01	150,000	150,000	02/01/02	0.0575	7,077	6
7	Mark Petersen	X		Working Capital	Interest	12/31/01	45,000	45,000	various	Prime		7
8												8
9	TOTAL Facility Related				$997.00		$ 254,816	$ 254,816			$ 7,077	9
	B. Non-Facility Related*											
10	Allocated from Management Company										287	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 287	14
15	TOTALS (line 9+line14)						$ 254,816	$ 254,816			$ 7,364	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.		$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2000	$ 3,673	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,673	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 3,632	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
	Prior owner payments	(3,632)	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 3,673	7

Real Estate Tax History:

2000 tax bill 3,673
2001 tax accrual use 3,632

Real Estate Tax Bill for Calendar Year:

1996		8
1997		9
1998		10
1999		11
2000	3,673	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie City Health Care Center COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0045377

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-000-022-05	Facility - Ground	$ 3,673.00	$ 3,673.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 3,673.00	$ 3,673.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,500 B. General Construction Type: Exterior Brick Frame Cinderblock Number of Stories 1 floor

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground
(such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 6,825
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 796
4. Dates Incurred: 2001

Nature of Costs: Legal Fees related to organization
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land	216,058	2001	$ 9,000	1
2					2
3	TOTALS	216,058		$ 9,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	48		2001	1970	$ 53,000	$ 849	39	$ 679	$ (170)	$ 679	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sewer Hook Up			2001	2,894	34	39	37	3	37	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 55,894	$ 883		$ 716	$ (167)	$ 716	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 55,894	$ 883		$ 716	$ (167)	$ 716	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 55,894	$ 883		$ 716	$ (167)	$ 716	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 55,894	$ 883		$ 716	$ (167)	$ 716	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 55,894	$ 883		$ 716	$ (167)	$ 716	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 55,894	$ 883		$ 716	$ (167)	$ 716	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 55,894	$ 883		$ 716	$ (167)	$ 716	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases	74,675	7,179	5,384	(1,795)	5-7	5,384	72
73	Fully Depreciated Assets							73
74	Allocated from Management Company			1,781	1,781			74
75	TOTALS	$ 74,675	$ 7,179	$ 7,165	$ (14)		$ 5,384	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Truck	2001	$ 28,915	$ 2,040	$ 2,892	$ 852	5	$ 2,892	76
77	Facility	2001 Chevy Van	2001	50,473	6,730	5,047	(1,683)		5,047	77
78										78
79										79
80	TOTALS			$ 79,388	$ 8,770	$ 7,939	$ (831)		$ 7,939	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 218,957	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 16,832	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 15,820	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,012)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 14,039	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Farnsworth - Expansion	$ 2,903	92
93			93
94			94
95		$ 2,903	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Management Co.				755			5
6								6
7	TOTAL				$ 755 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease . N/A

9. Option to Buy: [ ] YES [ ] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 2,604 Description: Copy Machine $ 2,078, Allocated from Management Company $526
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	N/A	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (4,375)	$ (4,375)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	57,635	57,635	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,988	3,988	6
7	Other Prepaid Expenses	11,414	11,414	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 68,662	$ 68,662	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,000	9,000	13
14	Buildings, at Historical Cost	55,894	55,894	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	154,063	154,063	16
17	Accumulated Depreciation (book methods)	(16,866)	(14,039)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,030	6,030	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Schedule 17A	2,903	2,903	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 211,024	$ 213,851	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 279,686	$ 282,513	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 81,167	$ 81,167	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	150,000	150,000	29
30	Accrued Salaries Payable	24,630	24,630	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	3,632	3,632	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	2,205	2,205	36
37	Intercompany Payable	40,000	40,000	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 301,634	$ 301,634	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	104,816	104,816	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 104,816	$ 104,816	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 406,450	$ 406,450	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (126,764)	$ (123,937)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 279,686	$ 282,513	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name **Prairie City Health Care Center**
Provider # **004537**
Period Ending **12/31/2001**

Schedule 17A

XV. BALANCE SHEET

A. Current Assets **Line 23, Other (specify)**	Operating	After Consolidation
Construction in Progress	2,903	2,903
Total	2,903	2,903

C. Current Liabilities **Line 36, Other Current Liabilities (specify)**	Operating	After Consolidation
Interest	754	754
Ins - General	1,451	1,451
Total	2,205	2,205

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(126,764)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (126,764)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (126,764)	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 550,761	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 550,761	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Vending Income 10 & Miscellaneous Income 2,991**	3,001	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,001	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 553,762	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	193,303	31
32	Health Care	276,137	32
33	General Administration	149,148	33
	B. Capital Expense		
34	Ownership	30,491	34
	C. Ancillary Expense		
35	Special Cost Centers	13,879	35
36	Provider Participation Fee	17,568	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 680,526	40
41	**Income before Income Taxes (line 30 minus line 40)****	(126,764)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (126,764)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
Entity files as a cash basis taxpayer

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,348	1,348	$ 21,666	$ 16.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,342	1,503	24,392	16.23	3
4	Licensed Practical Nurses	4,743	4,743	58,609	12.36	4
5	Nurse Aides & Orderlies	15,872	15,872	114,819	7.23	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,387	1,387	12,000	8.65	9
10	Activity Assistants	1,356	1,356	9,123	6.73	10
11	Social Service Workers	1,274	1,274	11,422	8.97	11
12	Dietician	57	57	1,369	24.02	12
13	Food Service Supervisor	1,277	1,277	11,176	8.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,796	6,796	41,798	6.15	15
16	Dishwashers					16
17	Maintenance Workers	882	882	7,534	8.54	17
18	Housekeepers	6,063	6,063	36,504	6.02	18
19	Laundry	1,353	1,353	8,867	6.55	19
20	Administrator	1,292	1,292	32,592	25.23	20
21	Assistant Administrator					21
22	Other Administrative	139	139	26,517	190.77	22
23	Office Manager					23
24	Clerical	401	401	7,008	17.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	45,582	45,743	$ 425,396 *	$ 9.30	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	25	$ 1,233	L. 1 C 3	35
36	Medical Director				36
37	Medical Records Consultant	5 Visits	98	L .10 C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L .10 C 3	39
40	Physical Therapy Consultant	6	383	L 10A C 3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	7	443	L 10A C 3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	23	664	L 11 C 3	44
45	Social Service Consultant	22	664	L 12 C 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	83	$ 4,685		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jill West	Administrator	0.00%	$ 6,092
Ed Franciskovich	Administrator	0.00%	26,500
James Petersen	Administrative	60.00%	18,494
Mark Petersen	Administrative	40.00%	8,023
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 59,109

B. Administrative - Other

Description	Amount
Management Fees (eliminated in column 7)	$ (2,697)
TOTAL (agree to Schedule V, line 17, col. 3)	$ (2,697)
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ginoli & Co	Accounting	$ 616
Altshuler, Melvoin and Glacer	Accounting	349
American Express	Accounting	1,750
ADP	Payroll	3,789
American Online	Computer Services	100
Mid America Programming	Computer Services	3,080
Siber Net	Computer Services	60
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 9,744

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 11,997
Unemployment Compensation Insurance	5,312
FICA Taxes	26,821
Employee Health Insurance	5,229
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,518
Allocated from Management Company	3,726
TOTAL (agree to Schedule V, line 22, col.8)	$ 54,603

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	1,628
Health Care Worker Background Check	
(Indicate # of checks performed 31)	372
Illinois Health Care Association	1,975
Various Dues	65
Various Licenses	1,400
Various Subscriptions	30
Allocated from Management Company	93
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,763

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,243
Seminar Expense	384
Allocated from Management Company	390
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,017

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name Prairie City Health Care Center
PROVIDER # 0045377
Period Ending 01/31/2001

Schedule 21C

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	9,744
Allocated from the Home Office - Computer Services	309
Allocated from the Home Office - Accounting AM&G	6
Allocated from the Home Office - Accounting Ginol	602
Allocated from the Home Office - Accounting Brighton	24
Allocated from the Home Office - Bush, Snyder & Associates	66
Total (agree to Schedule V, line 19, column 8)	10,751

See Accountants' Compilation Report

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 04/30/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $1,975**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **6.5 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **3,476** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **17,568**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	54,343	5,042	1,233	60,618	0	60,618	7	60,625
2. Food Purchase	0	34,461	0	34,461	0	34,461	0	34,461
3. Housekeeping	36,504	5,211	0	41,715	0	41,715	0	41,715
4. Laundry	8,867	4,290	0	13,157	0	13,157	0	13,157
5. Heat and Other Utilities	0	0	15,417	15,417	0	15,417	120	15,537
6. Maintenance	7,534	17,502	2,899	27,935	0	27,935	147	28,082
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	107,248	66,506	19,549	193,303	0	193,303	274	193,577
9. Medical Director	0	0	0	0	0	0	0	0
10. Nursing & Medical Records	219,486	20,408	1,298	241,192	0	241,192	0	241,192
10a. Therapy	0	0	826	826	0	826	0	826
11. Activities	21,123	246	664	22,033	0	22,033	0	22,033
12. Social Services	11,422	0	664	12,086	0	12,086	1	12,087
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	252,031	20,654	3,452	276,137	0	276,137	1	276,138
17. Administrative	59,109	0	-2,697	56,412	0	56,412	2,697	59,109
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	9,744	9,744	0	9,744	1,007	10,751
20. Fees, Subscriptions & Promotion	0	0	5,670	5,670	0	5,670	93	5,763
21. Clerical & General Office	7,008	2,769	11,136	20,913	0	20,913	2,845	23,758
22. Employee Benefits & Payroll	0	0	50,877	50,877	0	50,877	3,726	54,603
23. Inservice Training & Education	0	0	49	49	0	49	13	62
24. Travel and Seminar	0	0	2,627	2,627	0	2,627	390	3,017
25. Other Admin. Staff Trans	0	0	728	728	0	728	435	1,163
26. Insurance-Prop.Liab.Malpractice	0	0	2,128	2,128	0	2,128	540	2,668
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	66,117	2,769	80,262	149,148	0	149,148	11,746	160,894
29. Total General Administrative	425,396	89,929	103,263	618,588	0	618,588	12,021	630,609
30. Depreciation	0	0	16,867	16,867	0	16,867	-1,047	15,820
31. Amortization of Pre-Op. & Org.	0	0	796	796	0	796	0	796
32. Interest	0	0	7,077	7,077	0	7,077	287	7,364
33. Real Estate	0	0	3,673	3,673	0	3,673	0	3,673
34. Rent - Facility & Grounds	0	0	0	0	0	0	755	755
35. Rent - Equipment & Vehicles	0	0	2,078	2,078	0	2,078	526	2,604
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	30,491	30,491	0	30,491	521	31,012
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	0	0	0	0	0	0
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	17,568	17,568	0	17,568	0	17,568
43. Other (specify):*	0	0	13,879	13,879	0	13,879	-13,879	0
44. Total Special Cost Ce	0	0	31,447	31,447	0	31,447	-13,879	17,568
45. Grand Total	425,396	89,929	165,201	680,526	0	680,526	-1,337	679,189

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	-4,375	-4,375
2. Cash - F	0	0
3. Account	57,635	57,635
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	3,988	3,988
7. Other Pr	11,414	11,414
8. Account	0	0
9. Other (s	0	0
10. Total c	68,662	68,662
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	9,000	9,000
14. Buildin	55,894	55,894
15. Leaseh	0	0
16. Equipn	154,063	154,063
17. Accum	-16,866	-14,039
18. Deferre	0	0
19. Organi	6,030	6,030
20. Accum	0	0
21. Restric	0	0
22. Other l	0	0
23. other (s	2,903	2,903
24. Total L	211,024	213,851
25. Total A	279,686	282,513
CURRENT LIABILITIES		
26. Accour	81,167	81,167
27. Officer'	0	0
28. Accour	0	0
29. Short-T	150,000	150,000
30. Accrue	24,630	24,630
31. Accrue	0	0
32. Accrue	3,632	3,632
33. Accrue	0	0
34. Deferre	0	0
35. Federa	0	0
36. Other (	2,205	2,205
37. Other (	40,000	40,000
38. Total C	301,634	301,634
LONG TERM LIABILITES		
39.Long-Te	104,816	104,816
40.Mortgag	0	0
41.Bonds I	0	0
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lo	104,816	104,816
46.Total Li	406,450	406,450
47.Total Eo	-126,764	-123,937
48.Total Li	279,686	282,513

		Balance per Medicaid Trial Balance
1.	Gross F	550,761
2.	Discour	0
	Subtota	550,761
4.	Day Ca	0
5.	Other C	0
6.	Therapy	0
7.	Oxygen	0
	Subtota	0
9.	Paymer	0
10.	Other	0
11.	Nurses	0
12.	Gift an	0
13.	Barber	0
14.	Non-P	0
15.	Teleph	0
16.	Rental	0
17.	Sale o	0
18.	Sale o	0
19.	Labora	0
20.	Radiol	0
21.	Other	0
22.	Laund	0
	Subtot	0
24.	Contril	0
25.	Interes	0
	Subtot	0
27.	Other	3,001
28.	Other	0
	Subtot	3,001
30.	Total F	553,762
31.	Gener	193,303
32.	Health	276,137
33.	Gener	149,148
34.	Owner	30,491
35.	Specia	13,879
35.	Provid	17,568
37.	Other	0
40.	Total E	680,526
41.	Incom	-126,764
42.	Incom	0
43.	Net In	-126,764

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached
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19 The bottom right side of page under **, you must write in any comments
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RECONCILIATION REPORT **Prairie City Health Care** **03:51 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-1,337	equal to	-1,337	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	7,364	equal to	7,364	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	3,673	equal to	3,673	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	796	equal to	796	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	15,820	equal to	15,820	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	755	equal to	755	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	2,604	equal to	2,604	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	826	equal to	826	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies		equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	193,303	equal to	193,303	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	276,137	equal to	276,137	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	149,148	equal to	149,148	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	30,491	equal to	30,491	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	13,879	equal to	13,879	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	17,568	equal to	17,568	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	219,486	equal to	219,486	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	21,123	equal to	21,123	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	11,422	equal to	11,422	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	54,343	equal to	54,343	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	7,534	equal to	7,534	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	36,504	equal to	36,504	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	8,867	equal to	8,867	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	59,109	equal to	59,109	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	7,008	equal to	7,008	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	425,396	equal to	425,396	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	1,233	< or = to	1,233	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	0	< or = to		0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	1,298	< or = to	1,298	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	664	< or = to	664	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	664	< or = to	664	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	59,109	equal to	59,109	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	-2,697	equal to	-2,697	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	9,744	equal to	9,744	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	54,603	equal to	54,603	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	5,763	equal to	5,763	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	3,017	equal to	3,017	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	17,568	equal to	17,568	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	N/A	< or = to	3,726	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	N/A	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	15,422	equal to	15,422	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	254,816	equal to	254,816	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	3,632	equal to	3,632	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	9,000	equal to	9,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	55,894	equal to	55,894	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	154,063	equal to	154,063	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	14,039	equal to	14,039	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-126,764	equal to	-126,764	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-126,764	equal to	-126,764	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	279,686	equal to	279,686	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1